Making Sense of Bioethics
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Ethical Directives and the Care of Pregnant Women in Catholic Hospitals

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At the beginning of December, the American Civil Liberties Union filed a sweeping federal lawsuit against the U.S. Conference of Catholic Bishops over its *Ethical and Religious Directives* for Catholic hospitals, alleging that the Directives, with their prohibition against direct abortion, resulted in negligent care of a pregnant woman named Tamesha Means. Ms. Means' water broke at 18 weeks, leading to infection of the amniotic membranes, followed by spontaneous labor and delivery of her child. The child lived only a few hours.

During the course of these events, Ms. Means went a Catholic hospital in Michigan several times, and, according to the lawsuit, was sent home even as contractions were starting. The lawsuit not only suggests that she should have been given a drug to induce labor early on but claims this wasn't possible precisely because the hospital was Catholic and bound by the Directives. It further asserts that Catholic hospitals are not able to terminate a woman's pregnancy by inducing premature labor "even if necessary for her health," because to do so would be "prohibited" by the Directives.

In point of fact, however, the Directives would not prevent the early induction of labor for these cases. Not infrequently, labor is induced in Catholic hospitals in complete conformity with the Directives. Directive #47 (never mentioned in the lawsuit) is very clear:

> "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."

Deciding about whether to induce labor involves the recognition that there are two patients involved, the mother and her *in utero* child, and that the interests of the two can sometimes be in conflict. In certain situations — for example, when the child is very close to the point of viability and the pregnancy is at risk — it may be recommended to delay early induction of labor in the hope that the child can grow further and the pregnancy can be safely shuttled to a point beyond viability, allowing both mother and child to be saved. Sometimes expectant management of this

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kind is not possible. Each case will require its own assessment of the risks, benefits, and likely outcomes before deciding whether it would be appropriate to induce labor.

When a woman's water breaks many weeks prior to viability and infection arises, long term expectant management of a pregnancy is often not possible. In such cases, induction of labor becomes medically indicated in order to expel the infected membranes, and prevent the infection from spreading and causing maternal death. Early induction in these cases is carried out with the foreseen but unintended consequence that the child will die following delivery, due to his or her extreme prematurity.

Such early induction of labor would be allowable because the act itself, i.e. the action of inducing labor, is a good act (expelling the infected amniotic membranes), and is not directed towards harming the body-person of the child, as it would be in the case of a direct abortion, when the child is targeted for saline injection or dismemberment. The medical intervention, in other words, is directed towards the body-person of the mother, using a drug to induce contractions in her uterus. One reluctantly tolerates the unintended loss of life that occurs secondary to the primary action of treating her life-threatening infection.

On the other hand, direct killing of a human being through abortion, even if it were to provide benefit for the mother, cannot be construed as valid health care, but rather as a betrayal of the healing purposes of medicine at its most fundamental level. Such an action invariably fails to respect both the human dignity of the unborn patient and his or her human rights. It also gravely violates a mother's innate desire and duty to protect her unborn baby. If she finds herself in the unfortunate situation of having a severe uterine infection during pregnancy, she, too, would appreciate the physician's efforts to treat her without desiring to kill her child, even if the child may end up dying as an unintended consequence of treating the pathology.

The application of Catholic moral teaching to this issue is therefore directed toward two important and specific ends: first, the complete avoidance of directly killing the child, and, second, the preservation of the lives of both mother and child to the extent possible under the circumstances.

Based upon these ends, the *Ethical and Religious Directives* of the U.S. Conference of Catholic Bishops provide important ethical parameters for framing the appropriate treatment of both mother and unborn child in high-risk pregnancies, while simultaneously safeguarding the fundamental integrity of medical practice in these complex obstetrical situations.

Rev. Tadeusz Pacholczyk, Ph.D. earned his doctorate in neuroscience from Yale and did post-doctoral work at Harvard. He is a priest of the diocese of Fall River, MA, and serves as the Director of Education at The National Catholic Bioethics Center in Philadelphia. Father Tad writes a monthly column on timely life issues. From stem cell research to organ donation, abortion to euthanasia, he offers a clear and compelling analysis of modern bioethical questions, addressing issues we may confront at one time or another in our daily living. His column, entitled "Making Sense of Bioethics" is nationally syndicated in the U.S. to numerous diocesan newspapers, and has been reprinted by newspapers in England, Canada, Poland and Australia.